aycc
Arlington Youth Counseling Center

**Initial Case Referral Information**

670R Massachusetts Ave
Arlington, MA 02476

| Client Name: | Client Date of Birth: | Sex:<br>M or F |
|---|---|---|
| Address: | Town/Zip: | School Attending/Grade:<br>_____/_____ |
| Home Phone: | Cell Phone: | Work Phone: |
| When AYCC calls you, may we identify ourselves and the purpose of this call?<br>___ Yes, At which number(s) __Home __Cell __Work ___ No, please do not identify yourself | | |

| Who referred you to AYCC? | Relationship to the client:<br>__parent __caregiver __other: _____ |
|---|---|
| Please provide a brief summary for why counseling services are being sought for the client? | |

**Primary Health Insurance Provider:**

_____

**Mental Health Insurance Provider:**

_____

**Secondary Insurance Provider (if applicable):**

_____

**Secondary Mental Health Insurance Provider:**

_____

**Name as Listed on Insurance Card:**

_____

**Name of Subscriber:**

_____

**Card #**_____

**Subscriber Date of Birth** _____/_____/_____

**Group #**_____

| Parent/Legal Guardian #1: | Parent/Legal Guardian #2: |
|---|---|
| Address (if different than above): | Address (if different than above): |
| Telephone:<br>Home: _____<br>Cell: _____ | Telephone:<br>Home: _____<br>Cell: _____ |
| What days and times will the client be available for ongoing therapy? | |

**In the event emergency services are required before client's first appointment, please call the Crisis Intervention Team serving Arlington (781-893-2003.)**

Please fax this form to 781-316-3261 from 9am to 5pm weekdays or email to dhermann@town.arlington.ma.us